

Cranial Sacral Therapy Center

Patient Name (first) _____ (last) _____ (M.I.) _____

Parent/Guardian Name (first) _____ (last) _____ (M.I.) _____

Home/Cell Phone # _____ Home/Cell Best # _____

I give permission to CSTC to call and leave personal information at the above "best" telephone number. _____ (Initial)

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ DOB: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about us: _____

RELEASE OF INFORMATION

I give permission to the Cranial Sacral Therapy Center ("CSTC") to release information to other healthcare providers, my insurance company, attorney, assignees and/or beneficiaries. _____ (Initial)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPAA guidelines. A copy is available at my request. _____ (Initial)

RELEASE OF LIABILITY (legal representative/patient)

I release CSTC from any liability for injury or damages while using the facilities located at 138 Stockton Avenue, San Jose, CA 95126. CSTC will not be subjected to any claim, demand, injury or damages whatsoever, including, without any limitation to those damages resulting from acts of active or passive negligence, except for the sole negligence or willful misconduct, on the part of CSTC, their owners, officers, agents or employees. The patient, for himself/herself and on behalf of his/her executors, administrators, heirs assigns and successors does hereby expressly forever release and discharge CSTC, its owners, officers, employees, agents, assigns and successors from all such claims, demands, injuries, damages, actions or causes of action. I also agree that CSTC is not responsible or liable to patients for articles damaged, lost or stolen in or about the facility. _____ (Initial)

CANCELLATION POLICY:

We respectfully request a 24 hour notice of cancellation. If you have an emergency and cannot provide a 24 hour notice, please call as soon as possible and leave a message on our answering machine.

Cancellations without 24 hour notice will be charged a \$50 cancellation fee, payable at your next visit.

_____ (Initial)

I willingly consent to the therapy treatment provided by CSTC .

_____ (Initial)

My initials above indicate my full participation and agreement for the Cranial Sacral Therapy Center services:

Patient Signature and Date

Parent/Guardian Signature and Date

Printed Patient's Name

Printed Parent/Guardian Name

Cranial Sacral Therapy Center Patient Intake Questionnaire

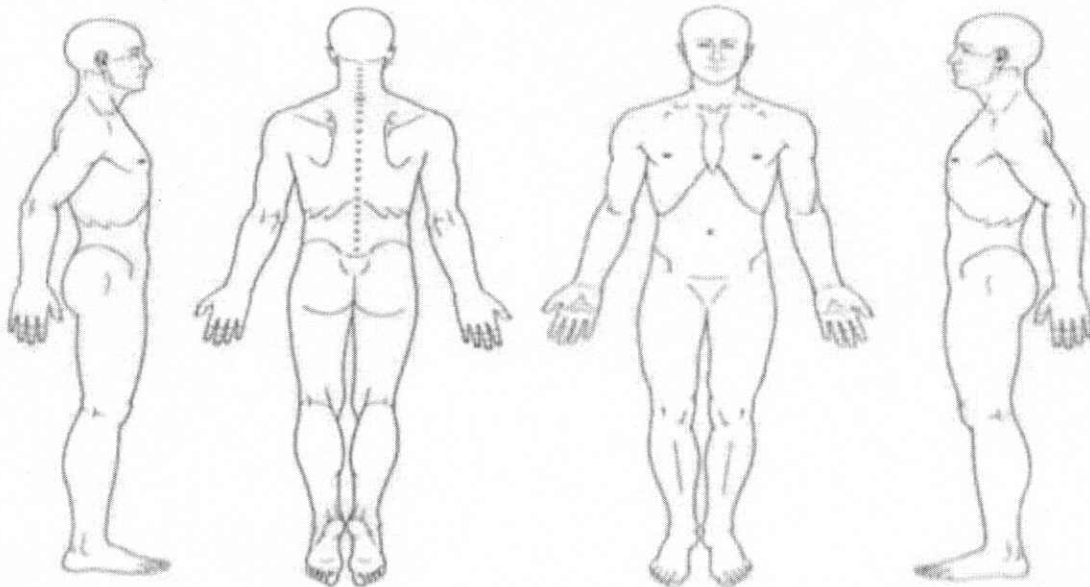
Patient Name: _____ Age: _____ Date of Birth: _____

Date: _____ Occupation/Work activities _____

Currently Working? Yes No Modified Currently a Student? Yes No Modified

Sports/Hobbies: _____

Please indicate your symptoms on the body chart below



How did your Problem begin? (Check all that apply)

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Sudden | <input type="checkbox"/> Fall | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> At Work | <input type="checkbox"/> Hit from Side | <input type="checkbox"/> At Home | <input type="checkbox"/> During Sports |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Hit From Behind | <input type="checkbox"/> No Apparent Cause | |

Other: _____

When did your Symptoms Begin? _____

Have you had Surgery for this problem? Yes No When? _____

What have you done for treatment thus far?

- Ice Heat PT Stretches Chiropractic Acupuncture

Other: _____

Medications _____

Is your sleep disrupted? ___ Yes ___ No

Please Prioritize your areas of complaint from body chart above:

Area 1: _____
Circle the words that describe
the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Area 2: _____
Circle the words that describe
the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Area 3: _____
Circle the words that describe
the pain:
Pain Ache Stiff Burning
Numb Weak Limited
Motion Sharp
Pounding Pins and Needles

Have they symptoms
changed in any way?
___ Better
___ Worse
___ Same

Have they symptoms
changed in any way?
___ Better
___ Worse
___ Same

Have they symptoms
changed in any way?
___ Better
___ Worse
___ Same

How often is there
pain/symptoms?
___ Constantly (100%)
___ Frequently (75%)
___ Intermittently (50%)
___ Occasionally (25%)

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CRANIAL SACRAL THERAPY CENTER PRICING POLICY

November 1, 2013

All fees are due at the time of service.

Adults:	
Cranial Sacral Therapy Session (2 hours):	\$250-\$300
Teenagers age 13 to 18:	
Cranial Sacral Therapy Session (1-1/2 hour):	\$200
Children under the age of 12:	
Initial Consult (1 hour):	\$125
Follow Up Consult (1 hour):	\$100
Homeopathy:	
Initial Consultation (1-1/2 hours to 2 hours)	\$375
Follow Up Consultation (30 to 45 min)	\$75
Brief Consult in the office or on the phone (15 to 25 min)	\$50
Joint Appointment with Kathleen (1 hour)	\$50
Neurofeedback	\$150
Neurofield	
QEEG	\$500
Sessions	\$100-\$200
Home/Hospital Visits -	
1-30 miles	Session fee + \$100
31-50 miles	Session fee + \$125
I have read and understand the fees for services policy:	
Patient Name	Date
Person Financially Responsible for Account	Signature

For Office Use Only:			
<input type="checkbox"/> 97140 Manual Therapy	<input type="checkbox"/> 723.1 Cervical	<input type="checkbox"/>	_____
<input type="checkbox"/> 90901 Bio Feedback	<input type="checkbox"/> 724.2 Thoracic Spine	<input type="checkbox"/>	_____
<input type="checkbox"/> Homeopathy	<input type="checkbox"/> 784.0 Lumbar	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> Headaches	<input type="checkbox"/>	_____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>	_____
Notes:			

CRANIAL SACRAL THERAPY CENTER
CREDIT CARD AUTHORIZATION FORM

Patient Name

Name of Person Financially Responsible for the Account

I authorize the Cranial Sacral Therapy Center to charge the credit card listed below for all services and products provided to me.

Credit Card Type: VISA MASTERCARD DISCOVER AMEX

Credit Card Number

Security Code

Expiration Date

Billing Address

City

State

Zip Code

Card Member Signature